

**Date:** [Insert Date]

**To:** [Name of School, Camp, or Organization]

**Address:** [Insert Address]

# Emergency Treatment Medication Administration Authorization

**Student/Participant Name:** [Full Name]

**Date of Birth:** [MM/DD/YYYY]

**Known Allergies/Medical Conditions:** [List Conditions]

To Whom It May Concern,

I, [Your Full Name], am the [Parent/Legal Guardian] of the above-named individual. I hereby authorize the staff, designated medical personnel, or emergency responders of [Name of Organization] to administer the following medication(s) to my child in the event of an emergency:

- **Medication Name:** [e.g., Epinephrine/EpiPen, Albuterol Inhaler]
- **Dosage:** [e.g., 0.3 mg]
- **Route:** [e.g., Intramuscular injection, Inhalation]
- **Specific Symptoms/Circumstances for Administration:** [e.g., Difficulty breathing, swelling of throat, loss of consciousness]

In the event that this medication is administered, I understand that emergency medical services (911) will be contacted immediately. I agree to indemnify and hold harmless [Name of Organization] and its employees from any claim or liability arising out of the administration of this medication.

## Emergency Contact Information:

Primary Contact Name: [Name] - Phone: [Phone Number]

Secondary Contact Name: [Name] - Phone: [Phone Number]

Physician Name: [Doctor Name] - Phone: [Doctor Phone Number]

This authorization is valid from [Start Date] to [End Date].

Sincerely,

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**Parent/Guardian Signature**

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**Date Signed**

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**Physician's Confirmation (Optional/As Required):**

I confirm that the above-named individual requires the medication listed above for emergency treatment.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_